Community Hospital Task Force II
Meeting #5 Notes
January 7, 2008
Rhode Island Department of Administration
Conference Room A, 1 Capitol Hill, Providence, RI

Commissioner Koller called the meeting to order at and asked the task force members to identify themselves.

Commissioner Koller discussed Attachment 2 regarding the updated workplan for the task force. Commissioner Koller explained that interim report has been drafted and discusses the choice of DRG grouper and the timeline for the task force as it continues. He also explained that due to time constraints of the consultants, the financial simulations will be presented on January 22.

Review timeline for implementing new Medicaid payment system (Director Alexander)

Director Alexander laid out a proposed process for the implementation of a new Medicaid payment system for hospital inpatient services. Using a framework proposed by ACS (attachment #3), Director Alexander discussed the need to have an internal working group for technical details, but to include a working group from hospitals to address implementation issues that will greatly affect hospitals. The implementation would require significant changes to the Medicaid Management Information System and thorough testing before the system was made live.

One Task Force member suggested that the CEO and CFO of every hospital be involved in a working group to collaborate with DHS on the implementation. Another suggested that the insurers be included as well.

Comment was made that if the expectation was for all insurers to adopt a very similar methodology – e.g., a similar grouper – the working group would need more input from other insurers beyond those represented at the table.

The goal is for the Task Force to set as much policy direction as possible.

One Task Force member asked where the legislative element of these changes would be. Director Alexander responded that most of the changes could be done in regulations.

Comment made that outpatient payment methodology would be addressed following inpatient methodology – per the consultants' recommendations to examine the methodologies sequentially.

Timeline for Medicaid to roll-out inpatient payment methodology changes is: 1) policy/legislation/regulation, 2) design, 3) implementation, 4) roll-out. Other payers would be integrated in this process if there is legislation that calls for it.

Options for other payers: what is the preferred option for having "similar payment method applied by all"?

The co-chairs addressed Attachment #4 – "Medicaid FFS vs. RIte Care vs. Commercial plans – Evaluating The Options." Pointed to three options for achieving the goal of "similar payment method applied by all." All three options would require mandates.

Tom Miller facilitated a discussion of Attachment #5 – "Continuum of Options for a "Similar" Inpatient DRG-Based Payment Method – Framework for Discussion."

Question – do we have any evidence of any results from the Maryland rate-setting experience? Response – Most recent review by the Maryland state legislature suggests that the growth of payment rates in the state is lower. What about community hospitals? Rate-setting reduces cost shifts between payers. Maryland has Medicare in this system too. Comment: Hospitals are at full-risk – four hospitals

have closed as a result. Comment: The cost of doing rate-setting – Maryland has a staff of 28 and a $4M budget.

Chris Koller stated that the fundamental issue is fairness – should hospitals get paid different weights for different services?

Question – how do you feel about government controlling more of the total payments to hospitals than they already do?

Comment: Don't want to move towards anything definitive yet.

Chris Koller: Need public testimony period with hospitals to gather their input on this point.

Comment: Need to start with a base payment that applies to all – if everyone negotiates their own base rate, you're not changing the system. Response – who makes the policy adjusters decision?

Comment: Why not start at the Medicare base rate?

Comment: A simple base rate is a good idea – we're trying to drive quality and service. Choice of a grouper should be made depending on whether the population is more similar to Medicare or Medicaid.

Comment on policy adjusters: the discussion on policy adjusters must be public and transparent. Where in the framework is the "public disclosure" aspect? In the "review and approve" function of a regulator.

Implications for RIte Care

John Young of DHS presented a set of slides on RIte Care as background for what adopting a "similar methodology" would mean for them. [See also slides.]

There are 110,000 folks in core RIte Care program, 2,200 in foster care, and 4,700 children with special health care needs.

RIte Care doesn't have plan-specific rates – instead, DHS establishes rates for all 3 plans. Capitation rates are common to all plans, by age and sex. Plan retains behavioral and pharmacy. Some benefits – like oral health – are not covered by plans.

The plans are at risk for delivering services. DHS has elected to not dictate provider rates to plans; instead, lets them shift payment rates between providers.

Most common DRGs are different for FFS and RIte Care. The average stay in FFS Medicaid costs 20-25% more than the average stay in RIte Care – which reflects a difference in both utilization and price.

Comments from other insurers

BCBSRI – Jim Purcell stated that affordability is a huge issue. The discussion had crossed into payment amount, but was really supposed to be about payment methodology. The question is, can we simply and get more efficient by having all payers adopt the same methodology?

BCBSRI states that insurers shouldn't adopt identical methods. Insurers should still be negotiating and working with providers on quality. Same method could mean the same grouper, or same type of grouper, but we haven't modeled the effect on hospital finances.

Recommendation from BCBSRI – need a measurable benefit to community hospitals. Need to know what resources are available to make a system change. Would be against rate-setting. Payment differential between what hospitals receive reduces when you look at outpatient and inpatient payments together. Complete transparency will have an impact on affordability.

United Healthcare – BJ Perry stated that the Task Force work has strayed far from its charge. United's preferred methodology is DRG-based, but have come to other agreements at the behest of the hospitals. There are valid differences in cost structures across facilities – so how would those be addressed in a public system? Technical issues inherent to implementing a new grouper are significant.

Other comments

What's the employers' view? Comment: RI Business Group on Health represents many different types of employers, but all are concerned about affordability.

Other comments raised by Task Force members:
Need to go back to the principle of fairness – why should there be a differential payment across hospitals?

Need a stable system across the board – need to address the systemic problem – maybe it's how we structure the payment system?

Need to know what we're *for*, not just what we're against. The status quo is not controlling overall costs. Quality is improving. We have a failing community hospital system. The system is eroding, but without a plan.

Medicare is contributing to hospitals' losses – and they're paying on a DRG-basis for inpatient care.

Shouldn't have an extreme on either end – having one base rate and quality adjusters are important for fairness.

There is concern about the state government's capacity to do anything.

Base rate should be evidence-based.

A middle ground could be reached with private negotiations with public disclosure.

Hospitals need to step-up – need to have incentives to increase quality.

Shouldn't we make the best hospitals survive based on people's needs? Shouldn't we figure that out first?

Fairness in rates doesn't mean lack of efficiency. Need to start with reallocation of money to hospitals. Need methodology first, then look at rate-setting.

Don't have enough information on what effect will be if all payers adopt the same base rate. Changing the rate doesn't get the state to a plan.

Change in method needs to be done in the context of a health plan.

Next steps
Co-chairs summarized next steps:

- Distribute red-line version of report noting Task Force members' suggested changes.
- Get testimony at next meeting in response to specific questions from HARI and Care New England.

Public comment

Mark Crevier: Current system doesn't reward quality. DRG-based system at least rewards the right things.